ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)

INTRODUCTION

This form is for collection centres/ labs to enter details of the samples being tested for Covid-19. It is mandatory to fill this form for each and every sample being tested. It is essential that the collection centres/ labs exercise caution to ensure that correct information is captured in the form.

INSTRUCTIONS:

- Inform the local / district / state health authorities, especially surveillance officer for further guidance
- Seek guidance on requirements for the clinical specimen collection and transport from nodal officer
- This form may be filled in and shared with the IDSP and forwarded to a lab where testing is planned
- Fields marked with asterisk (*) are mandatory to be filled

SECTION A – PATIENT DETAILS

A.1 TEST INITIATION DETAILS

*Doctor Prescription: Yes ☐ No ☐

(If yes, attach prescription; If No, test cannot be conducted)

*Follow up Sample: Yes ☐ No ☐

If Yes, Patient ID: ……

A.2 PERSONAL DETAILS

*Patient Name: ……

*Age: …. Years/Months ☐ age <1 yr, pls. tick months checkbox)

*Patient in quarantine facility: Yes ☐ No ☐

* Gender: Male ☐ Female ☐ Others ☐

*Present Village or Town: ……..……..…..…

*Mobile Number: ☐☐☐☐☐☐☐☐☐☐

*District of Present Residence:……

*Mobile Number belongs to: Self ☐ Family ☐

*State of Present Residence:……

*Nationality: ……..

*Present patient address: …….

*Downloaded Aarogya Setu App: Yes ☐ No ☐

……

(These fields to be filled for all patients including foreigners)

Pincode: ☐☐☐☐☐☐

Aadhar No. (For Indians): ☐☐☐☐☐☐☐☐☐☐☐☐

Passport No. (For Foreign Nationals): …….....

*A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type Throat Swab ☐ Nasal Swab ☐ BAL ☐ ETA ☐ Nasopharyngeal swab ☐

*Collection date

*Sample ID (Label)

*A.4 PATIENT CATEGORY (PLEASE SELECT ONLY ONE)

A.4.1 Routine surveillance in containment zones and screening at points of entry

Cat 1: All symptomatic (ILI symptoms) cases including health care workers and frontline workers..... ☐

Cat 2: All asymptomatic direct and high-risk contacts (contacts in family and workplace, elderly ≥ 65 years of age, those with co-morbidities etc. ☐

Cat 3: All asymptomatic high-risk individuals ..... ☐

A.4.2 Routine surveillance in non-containment areas

Cat 4: All symptomatic (ILI symptoms) individuals with history of international travel in the last 14 days..... ☐

Cat 5: All symptomatic (ILI symptoms) contacts of a laboratory confirmed case..... ☐

Cat 6: All symptomatic (ILI symptoms) health care workers / frontline workers involved in containment and mitigation activities ☐

Cat 7: All symptomatic ILI cases among returnees and migrants within 7 days of illness..... ☐

Cat 8: All asymptomatic high-risk contacts (contacts in family and workplace, elderly ≥ 65 years of age, those with co-morbidities etc. ☐

A.4.3 In Hospital Settings

Cat 9: All patients of Severe Acute Respiratory Infection (SARI)..... ☐

Cat 10: All symptomatic (ILI symptoms) patients presenting in a healthcare setting..... ☐

Cat 11: Asymptomatic high-risk patients who are hospitalized or seeking immediate hospitalization..... ☐

Cat 12: Asymptomatic patients undergoing surgical / non-surgical invasive procedures (not to be tested more than once a week during hospital stay).. ☐

Cat 13: All pregnant women in/near labour who are hospitalized for delivery..... ☐

Cat 14: All symptomatic neonates presenting with acute respiratory / sepsis like illness..... ☐

Cat 15: Patients presenting with atypical manifestations [stroke, encephalitis, hemoptysis, pulmonary embolism, acute coronary symptoms, Guillain Barre syndrome, Multiple Organ Dysfunction Syndrome,progressive gastrointestinal symptoms, Kawasaki Disease (in pediatric age group)]based on the discretion of the treating physician. ☐

A.4.4 Testing on demand

Cat 16: All individuals undertaking travel to countries/Indian states mandating a negative COVID-19 test at point of entry.. ☐

Cat 17: All individuals who wish to get themselves tested.……. ☐

Other: (please specify) * *(Select "other" only if the patient doesn't belong to category 1-17)*

SECTION B- MEDICAL INFORMATION

B.1 CLINICAL SYMPTOMS AND SIGNS

Symptoms: Yes ☐ NO ☐ If No please go to B.2 section

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Cough	☐	Diarrhoea	☐	Vomiting	☐	Fever at evaluation	☐	Abdominal pain	☐
Breathlessness	☐	Nausea	☐	Haemoptysis	☐	Body ache	☐		
Sore throat	☐	Chest pain	☐	Nasal discharge	☐	Sputum	☐		

Which of the above mentioned was First Symptom:..... **Date of onset of First Symptom:** ☐☐ ☐☐ ☐☐ **(dd/mm/yy)**

…….....

B.2 PRE-EXISTING MEDICAL CONDITIONS

Condition	Yes	Condition	Yes	Condition	Yes	Condition	Yes
Chronic lung disease	☐	Malignancy	☐	Heart disease	☐	Chronic liver disease	☐
Chronic renal disease	☐	Diabetes	☐	Hypertension	☐		

Immunocompromised condition: YES ☐ **NO** ☐ **Other underlying conditions:** ……

B.3 HOSPITALIZATION DETAILS

Hospitalized: Yes ☐ **No** ☐ **Hospital State:** ……

Hospital ID / number ☐ **Hospital District:** ……

Hospitalization Date: ☐☐/☐☐/☐☐ **(dd/mm/yy)** **Hospital Name:** ……

B.4 REFERRING DOCTOR DETAILS

Doctor Mobile No.: ……

***Name of Doctor:** ……..... **Doctor Email ID:** ……

** Fields marked with asterisk are mandatory to be filled*

TEST RESULT (To be filled by Covid-19 testing lab facility)

Date of sample receipt(dd/mm/yy)	Sample accepted/ Rejected	Date of Testing (dd/mm/yy)	Test result (Positive / Negative)	Repeat Sample required (Yes / No)	Sign of Authority (Lab in charge)